FYLDE COAST MENTAL HEALTH INTEGRATION PROJECT PAPER

Summary

This paper provides a review of the existing Mental Health services in scope for integration across the Fylde Coast with an overview of a workable model for integrated care between primary and mental health services in line with New Models of Care.

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1.0 Introduction

1.1 The five year Forward View 2015 identified why the NHS needs to change. The top five issues that citizens want to see improved include Mental Health services and integration of care. Recent publications - Mental Health and New Models of Care (Kings Fund May 2017) and Next Steps (NHS England Sept 2017) shifts focus to the next two years and how goals can be achieved.

There are a number of adverse effects identified nationally, which would be addressed by improving the integration between physical and mental health care teams:

1.2 Effects on people

- People with severe mental illness die 15-20 years earlier, largely as a result of poor physical health.
- Depression and anxiety lead to significantly poorer outcomes among people with diabetes, cardiovascular disease and other long-term conditions.
- There are well documented high rates of mental health conditions among people with long term physical health problems (30% of people with a long-term condition will experience a common mental health problem and 46% of people with mental health problems have a long-term condition).

1.3 Effects on systems

- People with mental health problems use significantly more unplanned hospital care for physical health needs than the general population - 3.6 times the rate for potentially avoidable emergency admissions.
- Poor management of medically unexplained symptoms adds to pressures in primary care, accounting for up to 30% of all GP consultations.

1.4 Effects on finances

- Between 12%-18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing.
- Medically unexplained symptoms are estimated to cost the NHS around £3 billion, evidence suggests this is additional to costs related to comorbid mental health problems or Long-term conditions (LTC).

1.5 Locally, across Lancashire the case for change is supported by:

- Higher levels of Emergency Admissions into Acute Hospitals.Higher levels of admissions for ambulatory sensitive conditions (Chronic Obstructive Pulmonary Disease - COPD, Diabetes, Coronary Heath Disease, Stroke).
- Poor uptake of NHS Health Checks.
- High referrals into Community Mental Health Teams (highest in England).
- Long standing disconnection between mental health and the rest of the care system.

1.6 In the Fylde Coast:

- There are a number of separate mental health services commissioned and multiple ‘single’ points of access to Mental Health services sitting outside the developing neighbourhood Teams.
- Our primary care workforce feels ill equipped to manage mental health conditions and GPs report access to support and services from mental health can be difficult and time consuming.

2.0 Background

2.1 The purpose of this paper is to propose the implementation of a model for the integration of Mental Health Community services with the developing primary care teams under New Models of Care. The mental health community teams in scope for integration are:

- Improving Access to Psychological Therapies (IAPT): Fylde Coast
- Supporting Minds Blackpool
- Minds Matter Fylde and Wyre
- Blackpool Single Point of Access (SPoA)
- Blackpool Primary Intermediate Mental Health Team (PIMHT)
- Blackpool, Fylde and Wyre Adult Community Mental Health Teams (CMHT)
- Fylde and Wyre Single Point of Access (SPoA)
- Fylde Coast Older Adults Single Point of Access (SPoA)
- Fylde Coast Older Adults Community Mental Health Teams (OACMHT)
- Lancashire Wellbeing Service (LWS)

2.2 Evidence has also shown that two thirds of people with a long-term physical health condition (LTC) also have a co-morbid mental health problem, mostly anxiety and depression and 70% of people with Medically Unexplained Symptoms (MUS) also have depression and/or anxiety disorders. Funding has been secured from the National IAPT team for the Fylde Coast IAPT services to be part of an early IAPT LTC implementer site wave 2. The funding is to train experienced IAPT staff in adapting therapy to work with LTCs, and also to fund new IAPT trainees (Psychological Wellbeing Practitioners - PWPs and Cognitive Behavioural Therapists) to backfill the IAPT staff being placed in LTC settings.

2.3 Integrating IAPT into these services will expand access to psychological therapies for people with Long term Conditions (LTC) or Medically Unexplained Symptoms (MUS). Identified IAPT therapists who have received additional training in IAPT LTC/MUS are beginning to integrate into physical health care pathways by offering IAPT psychological interventions for all Fylde Coast residents. Nationally, IAPT services have been set increased access rate targets (19% 2018-2019 and 25% by 2020-2021). It is expected that a significant proportion of the increased referrals will be made up from people with LTCs.

2.4 In line with national strategy and NHS transformation, the model for mental health integration has a focus on bespoke, whole person care in the community, hospital admission avoidance and support of early discharge. A key priority is to deliver integrated community mental and physical health care, which reflects the needs of the Fylde Coast population.

2.5 The paper describes current Mental Health provision across the Fylde Coast and determines an integrated model which is in synergy with the local NHS Vanguard and the CCGs ambitions. The challenge for the model is to achieve a safe clinical level of service which continues to achieve commissioned levels of capacity within the financial envelope.

2.6 The new models of care developed under the Fylde Coast Vanguard programme (Extensive Care Teams and Enhanced Primary Care Neighbourhood Teams) are currently at different stages of development across the Fylde Coast and this has impacted on the scope for change in delivering integrated Physical and Mental Healthcare.

2.7 As part of the process to develop and begin Mental Health integration on the Fylde Coast, the project team have regularly visited the Mental Health teams to talk through and share a brief overview of the Five Year Forward view, New Models of care and NHS transformation.

2.8 Baseline Measurements

2.8.1 The project group completed two baseline surveys to provide a snapshot of staff knowledge of current community services (Appendix 4) and patient experience (Appendix 5). Questionnaires were circulated during an identified working week in January 2018 to the staff in work and patients visited that week.

2.8.2 The surveys were conducted before implementing any changes to serve as a benchmark for examining what changes in staff knowledge and patient experience are triggered by the integration of Mental Health services. The same surveys are to be repeated in July 2018.

3.0 Overview of current Fylde Coast Mental Health Services in scope for providing links to locality neighbourhood teams

3.1 Mental Health Services operating across Blackpool, Fylde and Wyre:

3.1.1 **Adult Community Mental Health Teams** - There are three Adult CMHTs, one in each borough of the Fylde Coast. Service users in the care of the Adult CMHT's have a primary diagnosis of mental illness however it is not uncommon for physical health needs to be present which would require a joint approach to manage. Social workers are co-located in all three teams and provided by Blackpool Council and Lancashire County Council respectively; however, Blackpool social workers under local agreements focus on the requirements of the Care Act and no longer work as care coordinators under the care programme approach (CPA). The service operates Mon - Fri 9am-5pm.

Fylde Adult CMHT based at the Woodlands Resource Centre in St Annes
Wyre Adult CMHT based at the Mountcroft Resource Centre in Fleetwood
Blackpool CMHT based at The Football Stadium in Blackpool

3.1.2 **Older Adult Community Mental Health Team Fylde Coast** - This service operates across the whole of the Fylde Coast. It allocates to sub teams of Wyre, Blackpool North, Blackpool South and Fylde. The team provides a highly skilled multi-disciplinary approach, delivering high quality long-term interventions for older people with severe and enduring mental health problems. Typical service users are people of any age with a likely or confirmed diagnosis of dementia and any person over 65 with a functional mental health problem. The aim is to work closely with individual service users, their families, carers and other health/social care professionals in order to offer person centred holistic specialist care for an individual's mental health care needs. The key focus is one of therapeutic optimism and service users are assisted to maximise their quality of life by promoting recovery, social inclusion and how to live well with dementia and other significant mental health conditions. The service also provides assessment and specialist support to carers and families. Both Lancashire County Council and Blackpool Council social workers are co-located within the team however, Blackpool social workers under local agreements no longer work as care coordinators under the care programme approach. The service operates Mon - Fri 9am-5pm

3.1.3 **Older Adult Single Points of Access (SPoA)** - A daily Multi-Disciplinary Team (MDT) screens all incoming referrals which are then allocated to the urgent or routine care pathway. The team also delivers short-term work where there is no crisis or the crisis has stabilised and a less intensive time limited mental health intervention is needed. SPoA operates Mon – Fri 9am-5pm.

3.1.4 The Memory Assessment service was not in scope for this project, this team links into neighbourhoods and accommodates this through patient choice and availability of clinics. The Memory Assessment Service across the Fylde Coast aims to deliver quick and timely diagnosis to

people whose symptoms suggest that they may have dementia. They provide all patients who meet the referral criteria with a person-centred service, designed to empower people with dementia and their carers to make informed decisions about their care to help maximise quality of life. Involvement with the service should also help to reduce the risk of crisis later in the illness and enable the patient to be cared for at home for as long as is possible, whilst this is their preferred place of care.

There are three teams in the Fylde Coast area:

- Blackpool MAS Blackpool
- Fylde and Wyre MAS, Fleetwood
- Fylde Coast MAS, Lytham

3.2 Services operating across Blackpool

3.2.1 **The Supporting Minds (IAPT) service** for Blackpool CCG includes two Cleveleys practices. The service provides psychological interventions in line with National Institute for Clinical Excellence (NICE) guidance. The service is for anyone aged 16 plus who is experiencing common mental health problems such as anxiety, depression, feelings of panic, and stress. A range of interventions are offered at Steps 2 (low intensity) and 3 (high intensity), these include guided self-help, counselling, eye movement desensitisation and reprocessing therapy and stress control courses. These are offered in a range of community locations including GP, Primary health care and third sector settings across Blackpool and Cleveleys.

3.2.2 **The Blackpool Primary Intermediate Mental Health Team - SPoA** The team currently provides the Single Point of Access (SPoA) function for all complex mental health referrals in the Blackpool Footprint. This is staffed by a duty team who operate Monday to Friday 9-5pm consisting of qualified mental health practitioners who undertake initial triage assessment of all urgent/routine referrals before signposting to the most suitable service. A menu of service, clustering tool and liaison with secondary Mental Health services and neighbourhoods teams enables practitioners to determine the most appropriate pathway of care, with risk issues being a predominant factor during the allocation process.

3.2.3 **The Blackpool Primary Intermediate Mental Health Team – Localities (PIMHTs). The teams** are based in North and South Clinical areas and consist of senior mental health practitioners who are responsible for providing short-term treatments and integrated working. The team are skilled in managing mental health conditions, and establishing risk indicators to determine suitable treatment pathways for clients. The practitioners act as link workers to other mental health services and resources and take an active role in the community, surrounding the provision of education/guidance and the promotion of positive mental health to patients and health and social care colleagues. Interventions may be on an individual or group basis.

3.2.4 **The Blackpool Primary Intermediate Mental Health (PIMH) Team – Community Outreach.** The community outreach team consists of specialised practitioners that provide support to individuals with specific needs/diagnoses including Attention Deficit Hyperactivity Disorder (ADHD), Autism Spectrum Disorder, Families in Need, Older adults and Perinatal mental health, complex and chronic psychological and emotional difficulties. Referrals into the service are made via the SPoA service or via professionally led network meetings attended by PIMH clinicians.

3.2.5 **The Blackpool Primary Intermediate Mental Health Team – Consultant Psychiatrist.** The PIMHT consultant psychiatrist provides an outpatient clinic offering psychiatric evaluation for patients who are presenting with needs in the following areas:

- Mental health Diagnosis or Diagnosis Review and Management
- Identifying and Managing symptoms to minimise risk
- Effective use of medication

For some patients they will be seen in a nurse led follow-up clinic, which enables short term review of patients, who are then signposted for on-going support or discharged back to the care of the GP.

3.2.6 **Blackpool Council Mental Health Social Care** provides mental health social workers who are co-located in the Adult multi-disciplinary community mental health teams. They conduct Mental Health Act assessments, Care Act assessments and are involved in statutory work for secondary care mental health clients. Their work includes reviewing care needs, carer's assessment work and providing support and guidance to this complex and vulnerable client group.

3.4 Services operating across Fylde and Wyre

3.4.1 Minds Matter (IAPT) deliver non-urgent talking therapies to people 16 years and above, with mild to moderate common mental health problems. A variety of brief psychological interventions are available consistent with the Improving Access to Psychological Therapies programme.

3.4.2 Community Restart recognises the cost of social exclusion on people with mental illness and seeks to support them with engaging with their local communities, by building on existing skills and assets available. They offer support in building positive and helpful connections within local communities covering a wide range of statuary organisations, independent social enterprise groups and self-help forums. They are a 9am-5pm service, based with the Fylde & Wyre CMHTs.

3.4.3 The Lancashire Wellbeing Service is commissioned by Lancashire County Council to provide a free service offering short-term, practical support for the people of Lancashire who may be struggling with issues affecting their happiness and health. These may be concerns over;

- mental health and wellbeing - feeling anxious, stressed, isolated, or simply overwhelmed and unable to cope;
- health issues; – minor health conditions, fitness, diet and exercise;
- social issues - finances, mobility and transport, relationships and family, employment and housing.

Over a number of sessions they will coach and support the individual to change their behaviour to help improve their quality of life, better managing any mental or clinical health conditions.

3.4.4 Fylde and Wyre Adult Mental Health Single Point of Access team operates as a distinct function across the Fylde and is based with the Wyre CMHT at Fleetwood. The team provides triage of referrals into secondary Mental Health services. Professionals will provide short-term interventions and case management, signposting or referral and liaison to other services as required. The service operates Monday to Friday 9-5pm

3.4.5 The Fleetwood Consortia provides their own single point of access for Adult Mental health referrals separate to the Fylde & Wyre SPoA

Services not in scope of this project

3.5 Extensive Care Service

The Extensive Care service aims to greatly improve care for people who often need it the most by providing one comprehensive service for all of their needs in order to reduce their risk of hospitalisation. This means all the doctors, nurses, care co-ordinators and other professionals are in the same place, working together, to provide the necessary support to keep patients well for longer and out of hospital. The service is aimed at people aged 60 and above who have two or more long-term conditions, such as diabetes or chronic heart problems.

3.6 Enhanced Primary Care Neighbourhood Teams

Enhanced Primary Care (EPC) is for people who require the ongoing management of a long-term condition, such as diabetes or heart problems. Most GPs and practices would like to offer this as an ongoing service, but struggle because of the increasing day-to-day pressures they face.

Each 'neighbourhood' on the Fylde Coast has a dedicated local team of professionals who will keep in touch with patients and up-to-date on their condition. They will also advise on how to access other proactive help in their local communities such as voluntary groups and services.

This community-based team will consist of doctors, nurses, therapists, care co-coordinators and wellbeing support workers, plus other support staff, working together alongside local GPs to ensure that patients feel fully supported with their conditions and can stay as well as possible. The teams will also form close links with existing mental health and social care services to make sure all of a patients' needs are supported. However, the teams will not be identical across all areas of the Fylde Coast as individual neighbourhoods will require professionals with different skills to meet the needs of their local population.

4. Proposed model for Mental Health Integration (Appendix 1 & 2)

4.1 Integrated IAPT services Fylde Coast

4.1.1 Delivered by Supporting Minds Blackpool (Blackpool Teaching Hospitals) and Minds Matter Fylde and Wyre (Lancashire Care Foundation Trust), the services provide psychological interventions for people with mild to moderate common mental health problems, such as depression and anxiety, as part of the National IAPT programme. To be most effective IAPT services will align themselves with existing long-term condition (LTC) clinics, developing new wellbeing pathways that provide truly integrated care. This will mean that IAPT therapists will provide clinical input and 1:1 interventions in GP surgeries, outpatients' clinics held in hospital and community settings or other locations where LTC clinics are conducted. A range of LTC pathways will be developed incrementally with the initial focus on diabetes, muscular skeletal (MSK)/chronic pain and chronic obstructive pulmonary disorder (COPD). Evaluations will inform roll out into other LTC areas such as cardiovascular disease and medically unexplained symptoms. Roll out of the programme within IAPT is very much dependent upon colleagues in LTC negotiating shared space for co-location or individual therapy appointments. This is proving challenging; however as key relationships are established and evidence around outcomes and benefits are shared it is hoped that this will improve.

The current alignment of IAPT link workers is below:

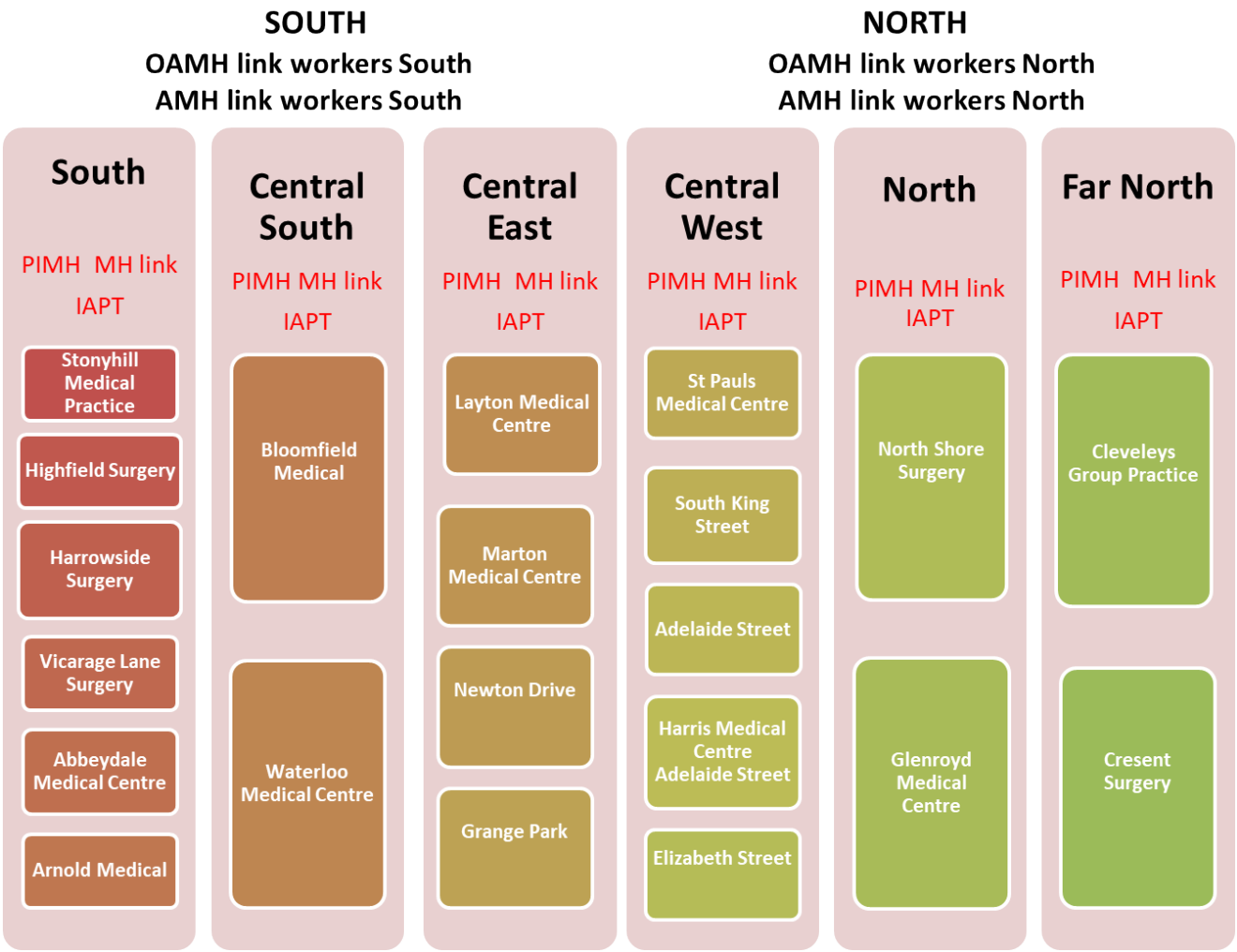
- IAPT link worker North Shore and Glenroyd Surgeries
- IAPT link worker South Shore Primary Care Centre
- IAPT link worker Diabetes Outpatients (one worker Fylde Coast wide for the LTCs)

- IAPT Link worker MSK/Chronic Pain
- IAPT Link worker COPD (still to agree pathway)

4.2 Accommodation and room availability in the community is a main concern for Mental Health service delivery overall in the developing community EPC Neighbourhoods and Hubs**.** These relate to room allocation for IAPT sessions, rooms for mental health appointments, hot desk space for Mental Health Link workers to joint work and Memory Assessment clinic space. The Project Team has worked as requested since August 2017, with the Vanguard estates work stream and projected an initial mental health need for space/room allocations.

4.3 **The Model Blackpool**

The diagramme below shows the six Enhanced Primary Care Neighbourhood Teams, each serving several GP Practices based on population size. In each team there is an IAPT Link Worker and a Primary Intermediate Mental Health Team Link Worker:



4.3.1 The PIMHT in Blackpool have allocated 4 qualified practitioners, who will work collaboratively in the role of Mental Health Link Worker (Appendix 3) in the Blackpool Neighbourhood Enhanced Primary Care teams (EPCs). These link workers are now attending the EPC Neighbourhood MDT meetings, acting as liaison practitioners, providing advice, guidance, and support to health and social care professionals on the identification and management of mental health problems. They also offer clinical expertise and joint working with EPC colleagues.

4.3.2 PIMHT has a dedicated consultant psychiatrist who will offer easy in, easy out psychiatric outpatient clinics to offer clinical advice to GPs around prescribing and support for people with complex mental health needs. Where the prescribing of an antipsychotic is advised the responsibility for the necessary physical health checks and review will remain with the prescribing GP.

4.3.3 A weekly interface meeting is held with Blackpool Adult Mental Health CMHT, CRISIS team and Accident and Emergency (A&E) Liaison to encourage and promote collaborative working across local adult mental health teams in Blackpool. This forum is available for other services to attend including

Supporting Minds, CAMHS, Young Offenders Team, Learning Disabilities Team, Fulfilling Lives and Horizon, within this meeting physical health conditions identified via the EPC meetings can be discussed to ensure this supports whole system health.

4.3.4 The Blackpool Adult CMHT is currently divided into two geographical areas, North and South, allocating staff to engage with patients dependent upon GP location. For the purpose of neighbourhood integration, it is proposed that the CMHT will identify link workers for North and South Blackpool. This way of working would complement their social work colleagues who are implementing a North and South way of working across the Blackpool area. The CMHT will adopt a whole team approach where any team member can provide the support to the EPC Neighbourhood Teams.

4.3.5 Blackpool Council's social care team have allocated two social workers to act as points of contact to the two EPC Neighbourhood Teams, however they are also adopting a 'whole team' approach where any member of the mental health social care team can liaise with EPC staff. This will ensure that any staff absence is covered and work is consistent. At a secondary care level, this level of support is felt to be adequate and appropriate as all MH social workers will be willing to engage in enquiries from EPC and others, who need guidance surrounding clients with long-term physical health conditions and mental health illness.

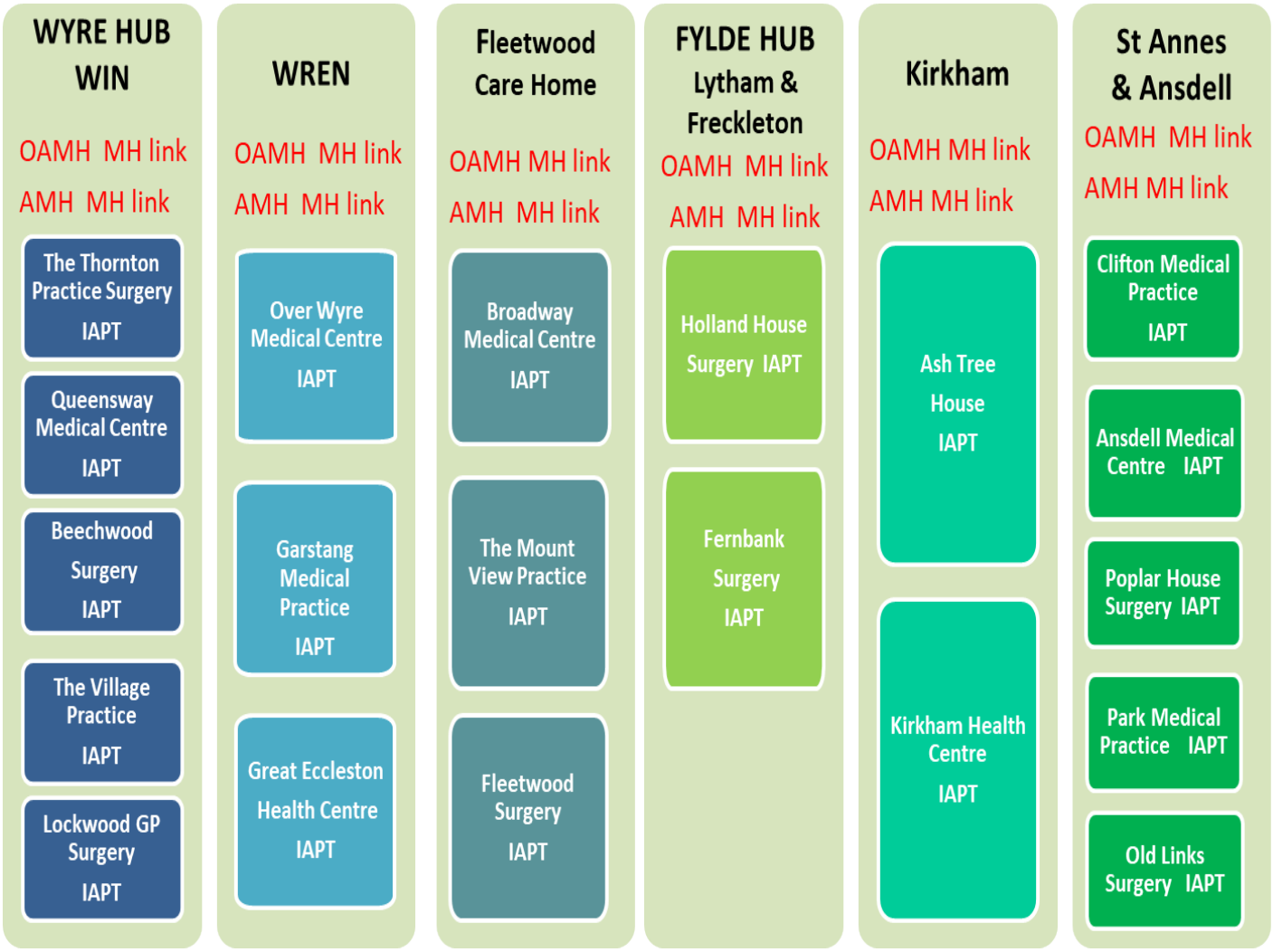
4.4 **The Model Fylde and Wyre**

WYRE

Wyre allocated Older Adult Mental Health and Adult Mental Health workers will attend the area MDT Clinical Meetings

FYLDE

Fylde allocated Older Adult Mental Health and Adult Mental Health workers will attend the area MDT Clinical Meeting



4.4.1 The neighbourhoods in Fylde and Wyre have established their EPC teams and are operating a Hub and spoke system. Link workers from CMHTs are attending the Fylde and Wyre EPC Hub meetings to provide liaison, advice, guidance, and support on the identification and management of mental health problems/relapse, offering clinical expertise and joint working to EPC colleagues**.** This robust link with the CMHTs will provide quick and easy access to mental health and consultant psychiatry opinion for people who are known to have complex mental health conditions when in relapse.

4.4.2 The Fylde and Wyre GPs are not at this time referring into the developing EPC Hubs and are operating their own individual MDT meetings at a surgery level. The Link Worker Service (LWS) will have a nominated link worker, attending the surgery MDT's taking low-level mental health cases, and linking with the nominated CMHT link worker for advice on referrals to any higher-level services. In the initial stages the referral pathway to both the older adult and adult mental health SPoA will remain unchanged. It is expected that as the Hubs develop to receive referrals they will become the point of entry for routine higher-level mental health referrals. At this point a whole time mental health referral point of access worker will work in the Hubs. The proposal is to develop an easy access mental health referral pathway that is closer to the patients, alongside a clear and robust urgent care mental health pathway across the whole Fylde Coast. There is a need for open discussion around resources in community mental health to fully support the EPC Neighbourhood Hubs in delivering primary mental health care in Fylde and Wyre.

4.4.3 As the Hubs develop and become a routine point of access for mental health referrals it is expected that Fylde and Wyre will develop an easy in easy out routine point of access supported by interface meetings similar to Blackpool to encourage and support collaborative integrated working across teams.

4.4.4 Easy access to Consultant Psychiatrist opinion is available to GPs around prescribing and support for people with complex mental health needs.

4.4.5 Lancashire County Council has recently informed LCFT of significant changes to the integrated Health and Social care model. These changes are not formalised, however the indication is that the Social Care element of CMHT's will be separate to the Health element and managed under a separate structure.

5. Mental Health training and development in the Hubs

5.1 The project team worked closely with the CCG's organisational development department in a small task and finish group to look at adding a Mental Health component to the existing New Models of Care Competency Framework. The group identified the 'Connect 5' training programme and discussions have been underway between the workforce work stream leaders around providing the train the trainer programme on offer via the Connect 5 programme.

5.2 Blackpool IAPT practitioners have provided mental health awareness training since April 2017. This has been open to Blackpool Teaching Hospitals staff, Blackpool Council staff and has also been attended by police and others who were made aware of the dates via the Mental Health Partnership Board. This is a monthly rolling programme with dates established to July 2018. The IAPT service is undertaking an evaluation and this will inform decisions about future training offers. The EPC Neighbourhood Teams access the Patient Activation Measures (PAM) model of training that provides staff with a clear understanding of the level of awareness the LTC patients have surrounding their physical health condition and what level of support is required. It has been suggested that the PAM training is to be accessed by mental health staff involved in neighbourhoods to enable and share a common tool which engages with clients at an appropriate level. EPC and LWS are currently piloting use of common assessment tools to be

completed for all referrals into the Neighbourhood teams, to be further developed to include a common entry level assessment for Mental Health.

5.3 New models of care and mental health integration offer an opportunity for peer education and learning across the different professional backgrounds and service lines. It is expected that this way of working in synergy will promote and encourage learning and understanding of common mental health conditions supporting the neighbourhood teams in managing these conditions and also support the mental health staff in understanding common physical health conditions. This supports the vision of the five year forward view and whole person, place based care in the future.

6. Baseline Surveys

The project group completed two baseline surveys to provide a general overview of staff knowledge of current community services (Appendix 4) and patient experience of mental health services (Appendix 5). Questionnaires were circulated during an identified working week in January 2018, to staff working in primary, intermediate and secondary mental health teams and to short-term and long-term patients in these services.

6.1 The snapshot survey and questionnaire undertaken by staff and patients provided valuable insight into the knowledge and ability our existing mental health work-force feel they have, surrounding access to community services at the present time. The patient questionnaires focussed on access and understanding of mental health services in our community. The staff survey was offered to practitioners within the primary, intermediate and secondary mental health teams. It clearly indicated that staff would benefit from gaining a more in-depth knowledge of available resources and to learn what community services are available to patients, as over half the 38 respondents consistently reported that they would benefit from having a wider knowledge base of obtainable services. However, there were a consistent number who reported they had a sound and extensive awareness of community services and felt confident in their understanding of resources. As the data anonymised the participants, it could not be ascertained if it was a particular staff group who felt more competent in their knowledge of community services.

6.1.1 Within the specified week, the patient questionnaires were distributed to the varied client groups of mental health teams, primary, intermediate and secondary. Of the 36 responses that were collated, the majority provided positive feedback regarding access to mental health services, awareness of the referral process and patient need taken into consideration. The majority of patients (28) had no idea of the type of mental health support they would receive and some stated that they had felt confused by the process. All patients felt that they had been treated with respect and sensitivity, with good explanations of mental health illness/care pathways being delivered.

6.1.2 The surveys were conducted before implementing any changes to serve as a benchmark for examining what changes in staff knowledge and patient experience are triggered by the integration of Mental Health services. The same surveys are to be repeated in July 2018.

6.1.3 This will provide a basis for developing and growing services and staff in the neighbourhoods alongside real time patient experiences of the mental health integration.

7. Identified risk and recommendation

No	Identified risk	Recommendation	Outcome
1	Neighbourhood MDTs are at different stages of development across the Fylde Coast footprint There are identified risks to the quality of patient care associated with changing the referral pathway before the neighbourhood teams are able to manage the routine MH access point within those teams.	1. No 'big bang' roll out of Mental health integration model until neighbourhood teams can support the change and there are enough SPoA MH link workers hours to support the neighbourhoods. Soft launch the integration model as localities develop. 2. Blackpool: OAMH CMHT will provide link workers and PIMHT will provide SPoA link workers directly to the EPC neighbourhood Teams. AMH CMHT link workers will be allocated to North/ South and attend weekly interface with PIMHT. 3. Wyre and Fylde: OA and AMH CMHT Link workers will attend hub clinical meetings.	Commenced January 2018. Wyre and Fylde MDTs have suggested MH staff to attend monthly initially.
2	Training i) EPC Neighbourhood Teams are in the process of providing PAMs training across all neighbourhoods. ii) EPC teams have reported they would appreciate specific MH training in identifying and managing mild conditions to avoid relapse.	It would be beneficial for mental health staff to access this form of training to ensure parity of care. Further development and decision around how basic MH training can be delivered to EPC teams via the Connect 5 training programme so they can support people with common MH conditions.	PAMs will ensure that EPC and MH staff have a clear understanding of measuring tools to determine appropriate care. EPC staff will have the skills to recognise common MH conditions and be able to understand and manage MH more effectively.
3	Service Gap within IAPT for housebound people in Fylde and Wyre who are unable to travel to appointments in neighbourhoods.	This group of people are currently being referred to secondary care mental health psychologists for IAPT interventions in their home. This part of the IAPT service would need investment to develop further and offer the same service to the housebound.	Further discussion needed around parity of care and IAPT to support this group of people.
4	There are identified risk factors for implementing full delivery of integration due to current issues EPC teams are experiencing with estates around lack of office space/clinic space. This will impact on the success of MH integration and accomplishing the future vision. All current availability has been collated	The neighbourhoods continue to work with the accommodation work stream and other providers in developing services in the localities. This includes liaison with senior commissioning group managers and attendance at strategic neighbourhood meetings.	On-going conversations across all service providers.

	via locality audits.		
5	Digital resources/IT systems There is a lack of access to IT systems across the Fylde coast. There is a lack of mobile equipment to support agile working in the Neighbourhoods	Each EPC Neighbourhood Team to promote and implement easy access to IT patient care recording systems. Better collaboration surrounding shared IT systems in services. Each Neighbourhood Hub to identify the IT systems that staff working in that Hub needs access to.	Use of existing digital resource to be promoted and others to be accessed, i.e: Lancashire.orcha.co.uk and FYI directory.co.uk Information regarding equipment has been fed to the IT work stream
6	Recording Systems All healthcare teams use different recording systems which do not easily link. Neighbourhood hub workers will need appropriate access to the necessary systems in the areas and teams they are working in.	Access for all practitioners to use all systems and be able to input Clear process in place regarding which system we are using for which patient Each organisation's responsibility to have enough staff enabled to utilise systems, even for read only	Information recorded and shared appropriately Patients care is continuous and consistent. Each organisation accountable for safe system use.
7	**Physical Health Checks** The project group have identified that establishing strong links between primary health and mental health teams will encourage partnership working in the MDT meeting. Developing a distinct wellbeing worker role would enable MH clients to have an easier link in accessing mental and physical health.	Investment to support the recruitment of these roles Standard Operating Procedure (SOP) which covers the governance of the neighbourhood teams/multi organisations	Demonstrating equity for people accessing services for both physical and mental health needs Increased uptake which will see improved data around PH monitoring in PC. Longer term financial benefits as people are less likely to progress into acute beds (both physical & mental health)
8	There is an ongoing need for sustained leadership, development and implementation of MH integration after March 2018	Resource development of MH provision. To have an identified MH professional and project manager providing steerage and direction to support the transitional work and deliver the changes in referral pathways, processes and operational procedures.	Continued and sustained transformation and implementation of full MH integration and provide steerage and direction.

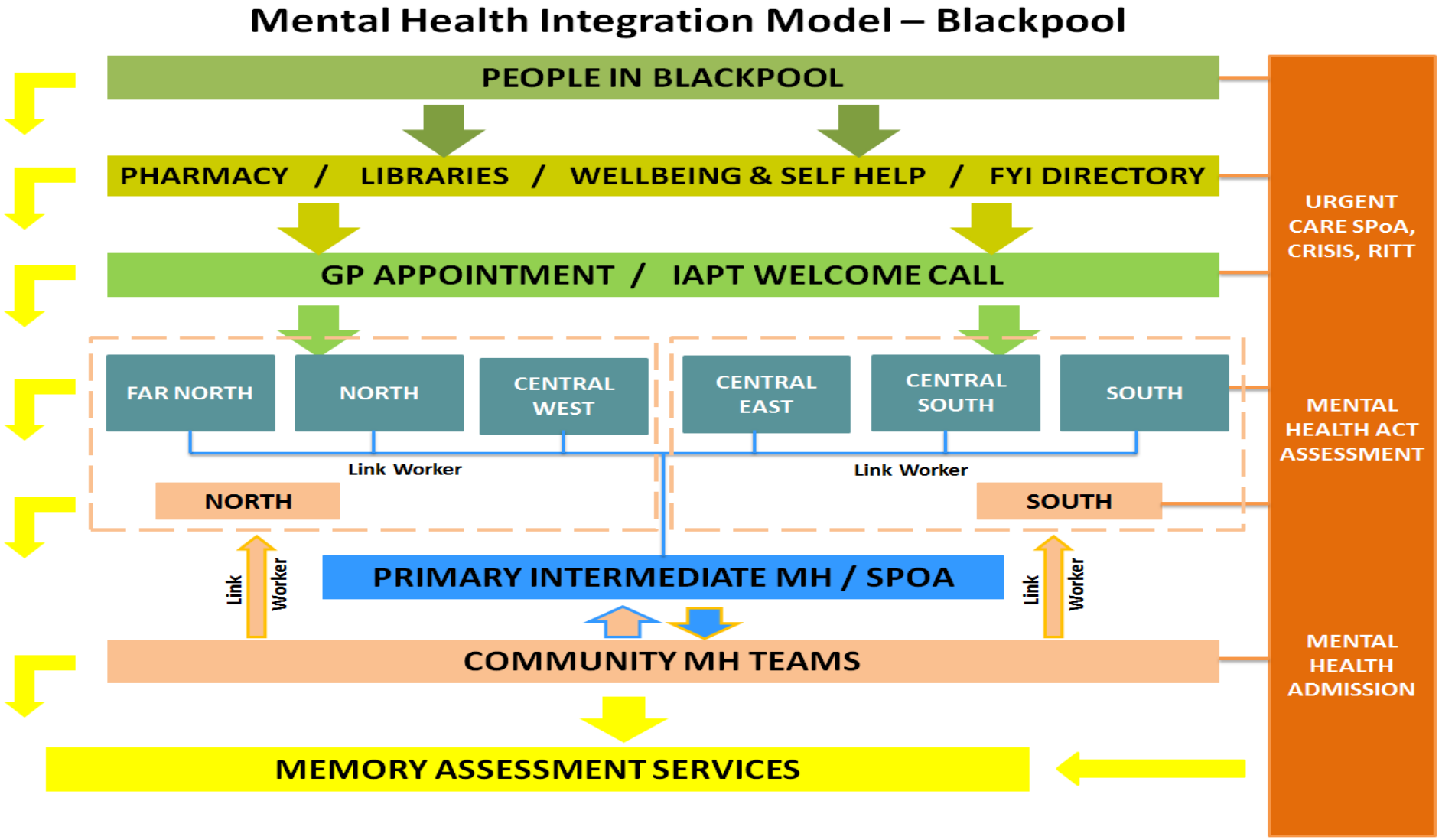
8. Conclusion

The aim of MH integration in the Fylde Coast community is to deliver a distinct integration model that incorporates changes in the ways of working between mental health and physical health teams, with the intent of avoiding hospital admissions and revolving presentations at GP surgeries. On the scale of what is expected, the changes can be achieved in the future, but at the present time the goal has been to deliver a 'bridge' that provides a realistic and achievable way of working in the community by delivering a higher level of care that reduces fragmentation in service delivery to improve the overall health outcomes for our residents.

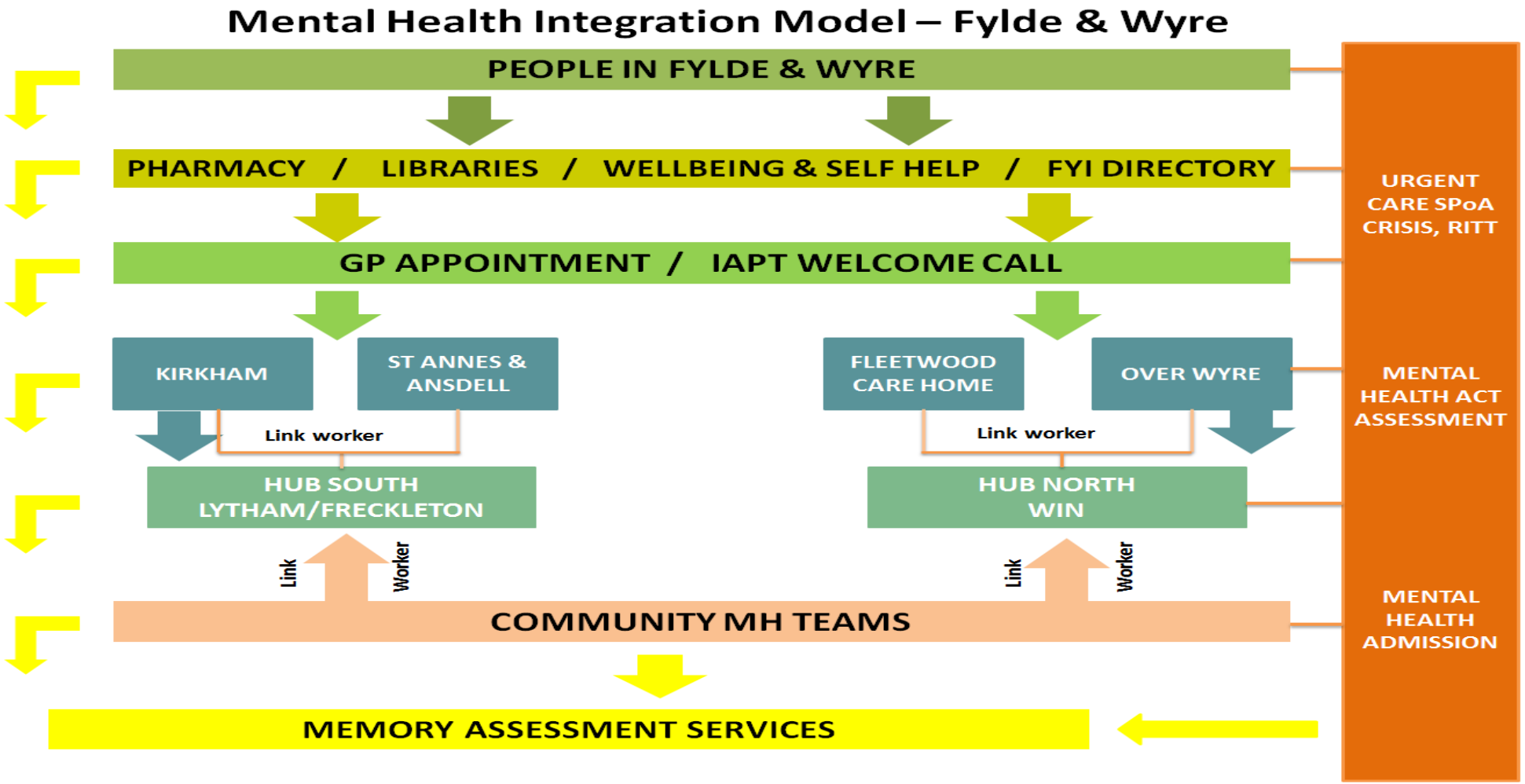
As mental health was not included in the original integration consultations in the Fylde Coast area, we have been able within 6 months to incorporate mental health links into the developing neighbourhood EPC teams from both primary and secondary mental health services. This has been accomplished with no additional finances or resources to meet the requirements of the evolving neighbourhoods and support the MH integration model.

However, the project requires future vision and growth to be successful and sustainable. Commitment surrounding funding, communication, accommodation and staffing will have to be addressed for ongoing joint work to continue successfully. This includes identifying specific mental health champions within the EPC's who can act as links with mental health and share skills collaboratively. This will enable the primary care workforce to increase their knowledge of mental health so that early recognition, signposting and appropriate intervention at initial stages of illness can reduce relapse and the need of secondary mental health interventions.

Appendix 1


Mental Health Integration Model – Blackpool
PEOPLE IN BLACKPOOL
PHARMACY / LIBRARIES / WELLBEING & SELF HELP / FYI DIRECTORY
GP APPOINTMENT / IAPT WELCOME CALL
FAR NORTH
NORTH
CENTRAL WEST
CENTRAL EAST
CENTRAL SOUTH
SOUTH
Link Worker
Link Worker
NORTH
SOUTH
Link Worker
Link Worker
PRIMARY INTERMEDIATE MH / SPOA
COMMUNITY MH TEAMS
MEMORY ASSESSMENT SERVICES
URGENT CARE SPoA, CRISIS, RITT
MENTAL HEALTH ACT ASSESSMENT
MENTAL HEALTH ADMISSION

Appendix 2


Mental Health Integration Model – Fylde & Wyre
PEOPLE IN FYLDE & WYRE
PHARMACY / LIBRARIES / WELLBEING & SELF HELP / FYI DIRECTORY
GP APPOINTMENT / IAPT WELCOME CALL
KIRKHAM
ST ANNES & ANSDELL
FLEETWOOD CARE HOME
OVER WYRE
Link worker
Link worker
HUB SOUTH LYTHAM/FRECKLETON
HUB NORTH WIN
Link Worker
Link Worker
COMMUNITY MH TEAMS
MEMORY ASSESSMENT SERVICES
URGENT CARE SPoA CRISIS, RITT
MENTAL HEALTH ACT ASSESSMENT
MENTAL HEALTH ADMISSION

Appendix 3

Link Worker Role

The aim of the mental health link worker will initially be a representative role from the existing Blackpool Primary Care SPoA, Adult and Older Adult CMHT Services identified as in scope for integration of new models of care across the Fylde Coast.

Mental Health Link workers will be dedicated professional practitioners assigned to neighbourhood teams across the Fylde Coast. As Neighbourhood working is evolving the initial integration of mental health will be via the MH link workers who will attend the neighbourhood teams Multi-Disciplinary meetings (MDT) where they will act as mental health link/liaison/point of contact.

Communication and relationship skills

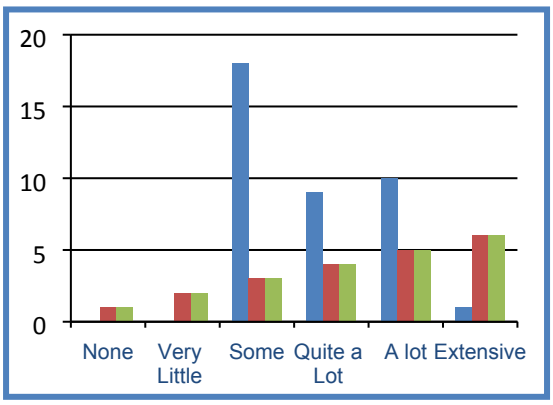
- The mental health link worker will offer clinical expertise and opinion to Neighbourhood MDT meetings, by providing advice and support to other health and social care professionals on the identification and management of mental health problems.
- Link workers will improve integration and information sharing via an MDT approach.
- Face to face contacts may also be facilitated with Neighbourhood MDT members.
- Signposting to services most appropriate to patient needs, including self-referral to IAPT and utilisation of third sector/voluntary services.
- Taking routine referrals from Neighbourhood EPC, MDT, meetings that meet the criteria for PIMH or Secondary Care Services.
- Fast track/easy access referrals of patients with existing mental health conditions when in relapse.
- Urgent care pathways remain unchanged at this time. However, Link Worker can be contacted and advice given to EPC of most suitable urgent care route.
- Memory Assessment pathways remain unchanged at this time.
- To provide effective risk assessment and risk management in partnership with service users and carers, supporting choice and self-determination.
- To advocate the use of recovery and a person-centred approach in all aspects of work with service users and carers.
- Recording on appropriate system where referral will be held. i.e. advice given after seeing patient in GP surgery would be recorded within GP patient record or similar PIMH recording system unless referral is going into secondary care as an open referral then it would go on Electronic Care Record (ECR)
- As transformation progresses it is envisaged that this role will evolve and change.

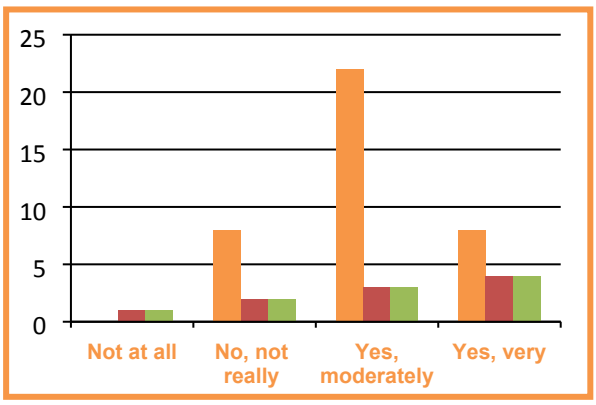
Key Relationships

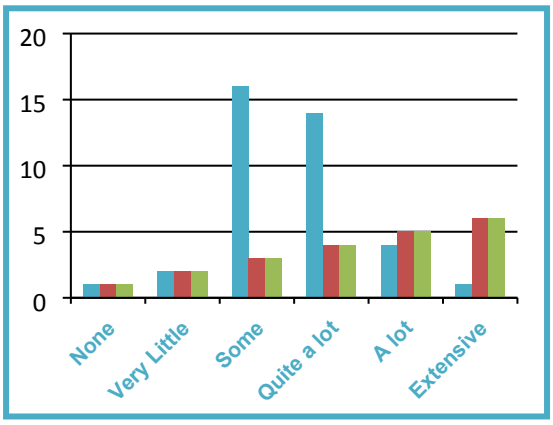
- Offers clinical expertise working towards earlier identification of mental health conditions,
- Preventative work at early stages reducing the need for secondary intervention.
- Role will provide peer support/education and pro rata.
- Collaborative approach to patient care.
- Contribute to improved outcomes and experiences of care of patients.

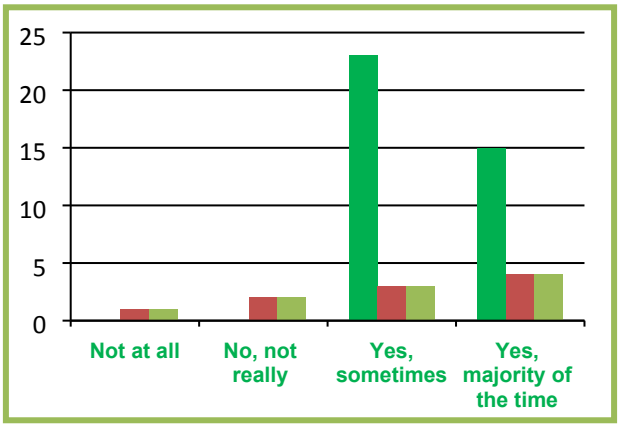
Appendix 4

Staff Survey Results
Vanguard Mental Health Integration Project
Number of Responses: 38









How would you estimate your level of knowledge about community services?
Do you currently feel confident in referring patients to the range of community services available?
How much knowledge do you feel you have about a community service when you make a referral?
Do you think you would benefit from knowing more about community service you may refer to?

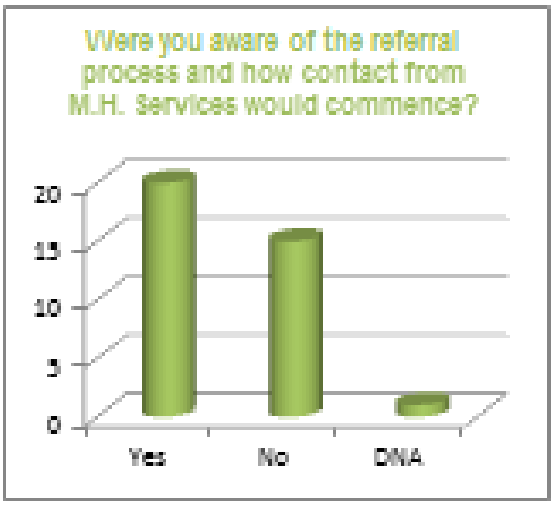
What would help for this to be achieved?

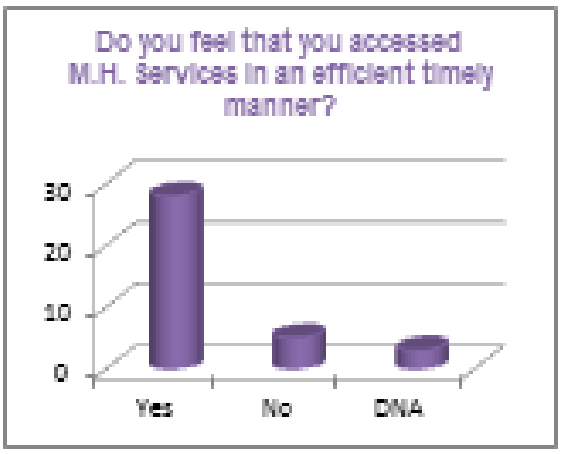
- *Communication to other teams when new initiatives are introduced or pathways or criteria change to ensure clients are referred to most appropriate services.*
- *Training / In-house training*
- *A4 printout with list of services / better knowledge of services available. What physical health teams/Care Home teams, clarity on geographical patches etc.*
- *List of services with brief description of what they offer / clear pathway for patients.*
- *Leaflets for patients / information packs for staff / Presentation / database of services / on line.*
- *Being given referral pathway for each service / an app if possible would be helpful*
- *Up to date list of community services and referral criteria/pathways.*

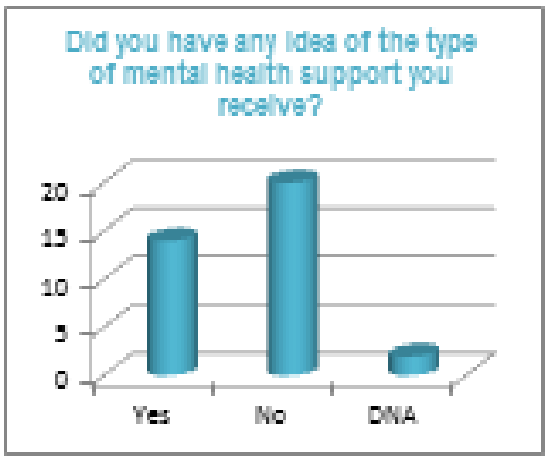
Appendix 5

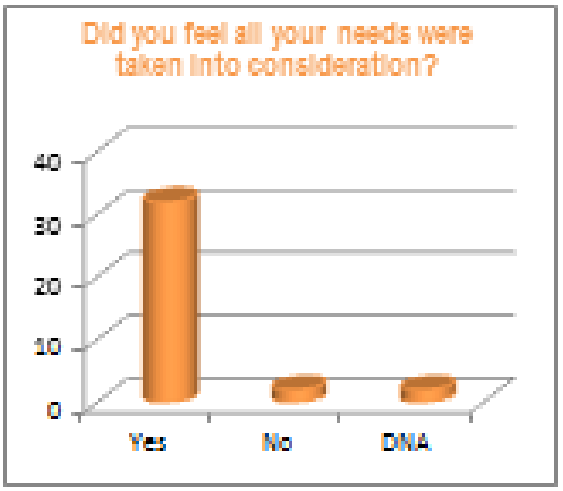
Patient Experience Questionnaire

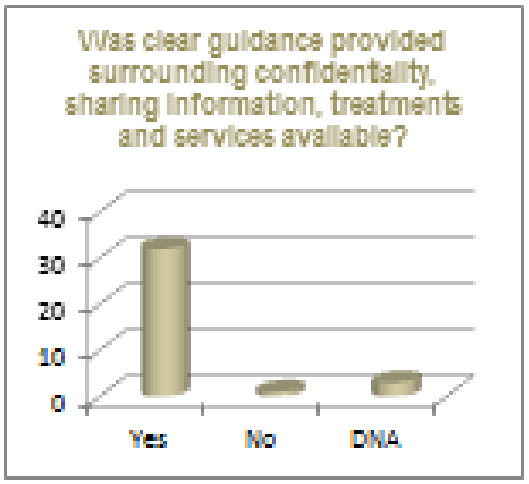
Completed Questionnaires: 36

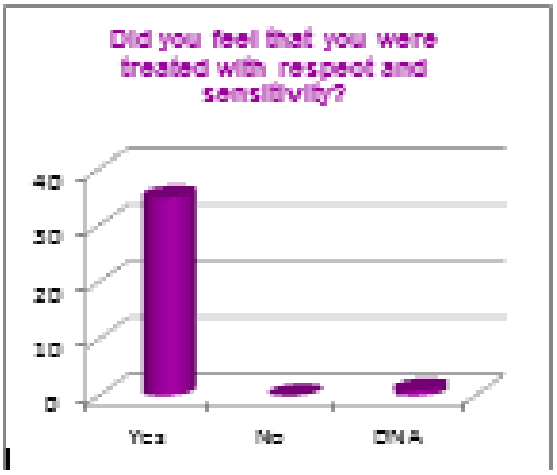












1. How did you access Mental Health Services?

   Comments: Easy process, good GP, quick process

   - Took 20 years for referral plus 18 months from GP referral to seeing a Psychiatrist.
   - Easy once wheels in motion
   - Accessed from hospital
   - Referred from Social Services. Rapid response due to crisis.
   - Referred with delirium whilst an inpatient at BVH following heart surgery.

2. Were you aware of the referral process and how contact from Mental Health Services would commence?

   Comments: Told by GP. Referred by GP. In Rest Home but aware of contact details should there be a concern. Previous dealings.

   - Unaware of process
   - Not until referral actually commenced
   - Was in hospital in crisis situation
   - Already under care of GP then referred to IST
   - Team met in hospital with me then monitored me from home
   - Crisis patient has dementia
   - Unsure
   - Not aware of referral as lacked capability and in acute phase of delirium

- Told I would receive a letter in the post

3. Do you feel that you accessed mental health services in an efficient timely manner?
   Comments: Had this condition for 4 years and never got help till now.
   - Can't recall as in crisis and 40 years ago
   - Because I was in hospital it all happened quite fast
   - No recollection. Does not acknowledge he has a MH problem
   - Waiting for a Psychiatrist
   - Long time waiting and no communication
   - Unable to comment as unaware of referral
   - Waiting times are long. Mental health is something that can't just wait to be looked over. It is a here and now problem that needs addressing quicker.

4. Did you have any idea of the type of mental health support you receive?
   Comments: Someone would visit me at home. I didn't know. Had previously.
   - Passed to a number of services over 3 years and very confusing
   - No discussion about what help is available
   - No idea due to crisis and how ill I was at that time
   - Too distressed as not coping in crisis situation
   - Was all explained to me in hospital
   - Not able to comment. Lacked awareness
   - When under CMHT regained capacity. Understood CPN's role to support with MH needs.

5. Did you feel all your needs were taken into consideration?
   Comments: Once in service I was able to accept what had happened to trigger the referral.
   - Must have at the time
   - Unable to comment. No recollection/crisis
   - Felt included in what was happening
   - Not able to say due to circumstances at the time
   - Ongoing over 3 years definate answer or treatment
   - Definitely
   - Very thorough assessment conducted

6. Was clear guidance provided surrounding confidentiality, sharing information, treatments and services available?
   Comments: Permission asked to talk to family.
   - At beginning
   - Fairly self-explanatory
   - Unable to say due to situation at that time
   - Once accepted into service knew what was happening
   - Good service. Shared information needed.
   - Not able to comment. Lacked awareness

- Once in service and able to accept trigger for referral and mental state improved, able to understand the information.

7. **Did you feel that you were treated with respect and sensitivity?**
   Comments: Unable to comment. No recollection/crisis/dementia.
   - At the time of the referral had no understanding of why I was being referred. Since mental state has improved feels all consideration has been given.
   - At all times
   - Felt understood by worker
   - Definitely
   - My sexual orientation felt like I had been well accepted with no judgement what so ever.

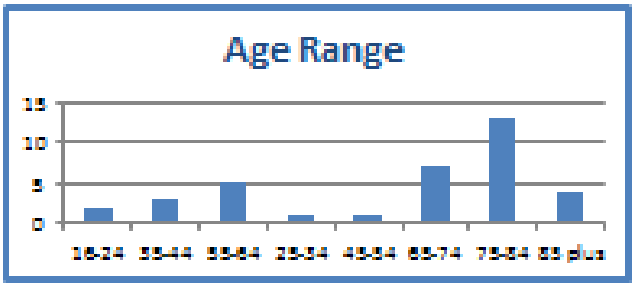
8. On contact with mental health services did you find the mental health practitioner competent in providing an explanation for possible causes of different mental health problems, care pathway, treatment and support options?
   Comments: Unable to comment. No recollection/crisis/dementia.
   - Yes made aware was temporary state related to physical health problems.
   - Provided all information about causes of illness
   - At that time 40 years ago felt was just put on a treadmill and became part of the system until discharge when things improved
   - Clear and informative
   - Now aware of the process
   - Struggles to read and write. This was treated respectfully.
   - He described other treatments I could access and told me how they would help me in relation to my personal problems.

9. **Was the environment satisfactory?**
   Comments: Rooms aren't inviting or comfortable. For someone with sensory issues the lights are bright and heating/aircon is loud.
   - Seen at home and then at nursing home
   - Waiting times, environment not friendly
   - Not clearly labelled. Confusing.
   - Was seen at home
   - Home. See Consultant at hospital in nice office
   - Small room and noisy outside
   - Absolutely fine
   - Was in hospital at the time
   - Had home assessment then admitted to Lancaster and transferred to Lytham Hospital a day later.
   - Always went into another room off the ward
   - At the time was in BVH and unaware what was happening, was angry and confused. Very happy with current arrangements at home visits.

If anything what could have been better about the service?

- *Timing. Appointments could have a smaller waiting time. Had to wait for an appointment for a month.*
- *Excellent service*
- *Crisis team on telephone*
- *Administration could be better*
- *Less waiting time*
- *More MH professionals*
- *No, excellent*
- *A bit near home*
- *Nothing. Happy with everything*
- *Better communication in relation to services*
- *Reduced waiting times especially for meds*
- *Didn't feel able to put point across at that time*
- *When an inpatient more activities to occupy time during hospital admission*
- *No problems with service provided*

About you – Age Range



Gender

Male = 11 Female = 25